Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005008	A. BUILDING: _____ B. WING _____	01/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE HOSPITAL INC	4321 FIR ST EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: 33212 Facility Number: 005008 Type of Survey: State Licensure Off Site JCAHO Accreditation Survey Date of JCAHO On Site Survey - Hospital full survey 1/21-24/2014 Date of ISDH off site review - 4/1/2014 Reviewer/Surveyor -Nancy Otten, RN, PHNS Based on review of the 1/21-24/2014 JCAHO Accreditation Survey Report, it has been determined that St. Catherine Hospital meets the requirements for Hospital Licensure in Indiana for 2014.	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE